Authorization for Administration of Medication at School

THIS PORTION TO BE COMPLETED BY PHYSICIAN/DENTIST

Name of Medication _____ Dosage _____ x _____

Time to be given _____ ☐ AM ☐ PM

Method of Administration ☐ Orally ☐ Other _____

Inhalers: Self-administer ☐ Yes ☐ No

Storage instructions: ☐ Room temperature ☐ Refrigeration

Reason for medication_____

Possible side effects_____

Starting Date ____/____/____ Ending Date ____/____/____

I request and authorize the above-named student be administered the above-named medication in accordance with the instructions indicated. I will be monitoring the ongoing health status of this patient.

Physician Address
_____
_____
_____

Physician Contact Numbers
(____)_____ office
(____)_____ fax

Physician Signature_____ Date ____/____/____

This Portion to be completed by parent/guardian

I certify that I am the parent, legal guardian or other person in legal control of the above - named student. I have read this form and request and authorize the school to administer the medication is to be furnished by me in the ORIGINAL prescription container.

I understand my signature indicates that the school accepts no liability for untoward reaction when the medication is given in accordance with the physician/dentist.

Parent/Guardian Signature_____ Date_____

IF MORE THAN ONE MEDICATION IS TO BE ADMINISTERED PLEASE FILL OUT THE REVERSE SIDE.

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Starting Date ____/____/____ Ending Date ____/____/____

I request and authorize the above-named student be administered the above-named medication in accordance with the instructions indicated. I will be monitoring the ongoing health status of this patient.

Physician Address
_____

Physician Contact Numbers
(____)_____ office

_____ (____)_____ fax

_____

Physician Signature_____ Date ____/____/____

This Portion to be completed by parent/guardian

I certify that I am the parent, legal guardian or other person in legal control of the above - named student. I have read this form and request and authorize the school to administer the medication is to be furnished by me in the ORIGINAL prescription container.

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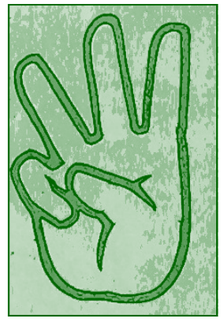
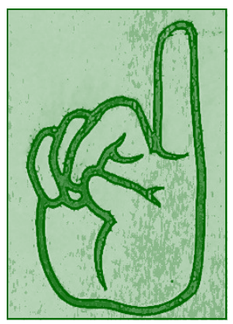
Parent/Guardian Signature_____ Date_____





Health Information

2006 - 2007

Washington School for the Deaf

Student Health Record

Student _____ Sex: ☐ M ☐ F Bithdate _____
Last First Middle

Parent/Guardian _____ _____
Last First Initial

Address _____
Street City State Zip

Dear Parent:
Please describe your child's health problems on the form below. It is important that you keep the school informed of any changes in health or medication which would affect your child's performance. If your child needs to take medication at school, please notify the school nurse.

☐ The health condition that I have described below is of sufficient concern that I would like to consult with the school nurse, I therefore agree to contact the school nurse at (360) 696-6525 ext. 4333 or (800) 613-4228 ext. 4333.

HEALTH HISTORY		
ASTHMA	Type: Special Needs:	A
BLOOD DISEASE Anemia, Hemophilia, etc.	Type: Special Needs:	B
CARDIAC	Type: Special Needs:	C
DIABETES	Medication: Special Needs:	D
SEVERE FOOD ALLERGY	Type: Special Needs:	F
DIGESTIVE DISORDER Food Intolerance, etc.	Type: Special Needs:	G
HEARING IMPAIRMENT OR COMPLETE LOSS	Describe: Special Needs:	H
INSECT STING ALLERGY	Type: Describe reaction:	I
MALIGNANCY	Type: Special Needs:	M
NEUROLOGICAL PROBLEM Hydrocephalus, Cerebral Palsy	Type: Special Needs:	N
ORTHOPEDIC PROBLEM Arthritis, Muscular Dystrophy, etc.	Type: Surgeries: Limitations:	O
RESPIRATORY PROBLEM Cystic Fibrosis, etc.	Severity: Medication: Special Needs:	R
SEIZURE DISORDER Epilepsy, etc.	Type: Medication: Special Needs:	S
URINARY/KIDNEY DISORDER Nephritis	Type: Special Needs	U
VISION IMPAIRMENT OR COMPLETE LOSS	Describe: Special Needs:	V
DRUG ALLERGY	Medication: Special Needs:	W
SERIOUS ILLNESSES/INJURIES	Describe: Special Needs:	
SKIN PROBLEMS Eczema, etc.	Describe: Special Needs:	
VISION PROBLEMS	Glasses: Contact Lenses:	
OTHER HEALTH PROBLEMS	Describe: Special Needs	

☐ None of the above to my knowledge
☐ CHECK HERE IF ANY OF THE ABOVE HEALTH CONDITIONS CONCERNING YOUR CHILD ARE LIFE THREATENING.
If so, state law requires that medication/treatment orders and a nursing plan be in place before the student attends school (RCW 28A.210 Sec. 1).

Parent/Guardian Signature Date

Student Name_____ Age_____ Birthdate_____

Allergies_____ Date of Last Tetanus Shot_____

Medical Care
This is to authorize Washington School for the Deaf medical staff and/or other doctors so designated to provide medical treatment to my student and administer anesthetic by qualified personnel if it become necessary. Washington School for the Deaf staff has the right to give first aid treatment to any student, and to seek and retain medical emergency or rescue services to treat, transport and/or hospitalize a student.

Parents/guardians are responsible for providing payment or medical insurance coverage for their student including medical expenses, evacuation and/or emergency transportation charges. Washington School for the Deaf does not provide medical insurance coverage for students and will not held responsible for medical expenses under any circumstance.

Parent/Guardian Signature Date

STUDENT INFORMATION				
STUDENT'S NAME LAST FIRST MIDDLE INITIAL				
ADDRESS STREET CITY STATE ZIPCODE				
HOME TELEPHONE	BIRTHDATE	AGE	SEX	EMAIL
PARENT/GUARDIAN INFORMATION				
NAME OF PARENT/GUARDIAN LAST FIRST MIDDLE INITIAL				
MOTHER'S CELL PHONE/PAGER V/TTY			FATHER'S CELL PHONE/PAGER V/TTY	
MOTHER'S EMAIL/PAGER ADDRESS			FATHER'S EMAIL/PAGER ADDRESS	
FATHER'S EMPLOYER				
EMPLOYER'S ADDRESS			PHONE NUMBER	
MOTHER'S EMPLOYER				
EMPLOYER'S ADDRESS			PHONE NUMBER	
INSURANCE INFORMATION				
NAME & ADDRESS OF INSURANCE COMPANY				
POLICY & GROUP NUMBERS/MEDICARE/UNION AND LOCAL			MY INSURANCE IS THROUGH _____Employment _____Private	
NAME & ADDRESS OF INSURANCE COMPANY				
POLICY & GROUP NUMBERS/MEDICARE/UNION AND LOCAL				
EMERGENCY CONTACT				
PLEASE LIST IN ORDER WHO YOU WOULD LIKE US TO CONTACT IN THE CASE OF AN EMERGENCY				
1		Relationship	Phone	
2		Relationship	Phone	
3		Relationship	Phone	
4		Relationship	Phone	

Student Information

Authorization for Administration of Medication at School

Student Name_____

Hearing Loss History

Cause of hearing loss: _____

Age of onset: _____ Age of diagnosis: _____

Other family members with hearing loss? ☐ No ☐ Yes Who? _____

Student has tubes or holes in eardrum(s) NOW? ☐ No ☐ Yes -- ☐ Right ☐ Left ☐ Both

Student needs earplugs? ☐ No ☐ Yes, I will send earplugs for swimming/showering

☐ I prefer to clean my student's ears myself.

☐ I give permission for the WSD nurses to instill medications and/or water in to my student's ears to clean them as needed.

_____

Parent/Guardian Signature Date

Heart History

Long QT Syndrome, LQTS, is a hereditary abnormality of the heart's electrical system that can cause cardiac arrest and sudden death. LQTS is very rare and occurs more often in people who were born deaf than to hearing people or those who lost their hearing after birth.

Have any of your student's family members had a sudden unexplained death? ☐ No ☐ Yes (if checked please respond below)

Who?_____ When?_____

Has your student ever fainted? ☐ No ☐ Yes (if checked please respond below)

When? _____ How often?_____

Your student should be screened for LQTS if:

- A family member had a sudden unexplained death, and/or
- Your student has ever experienced fainting spells.

Has your child ever been screened for LQTS? ☐ No ☐ Yes (if checked please respond below)

Who did the evaluation? _____ What were the results? _____

I understand that if my student is at risk for LQTS as explained above, it is my responsibility to have him/her screened by my family doctor.

_____

Parent/Guardian Signature Date

Authorization for Administration of Over-the Counter Medications

The Student Health Center Medical Director has authorized WSD nurses to give certain over-the-counter medications for the treatment of minor injuries and illnesses (see enclosed list.) Before giving your student any medications, the nurse checks your student's medical history, allergies, and any other medications your student is taking to make sure there is no conflict. You will always be notified immediately of any serious illness or injury.

☐ I give WSD nurses permission to treat my student for minor injuries and illnesses with the over-the-counter medications ordered by the Student Health Center Medical Director (Pediatrician).

☐ I prefer that the WSD nurses call me before giving any over-the-counter medications to my student.

_____

Parent/Guardian Signature Date

Over the Counter Medications

Examples of Over-the-Counter Medications

Authorized by the Student Health Center Medical Director

HEALTH COMPLAINT	EXAMPLES OF MEDICATIONS USED
Acne	Phisoderm cleanser, benzoyl peroxide or cream
Allergies	Benadryl, Chorpheniramine, Claritan, Benadryl, Sudafed
Athlete's foot	Lotrimin, clotrimazole
Bee sting	Monosodium glutamate, Benadryl Cream
Clean pierced ears	Rubbing alcohol, hydrogen peroxide
Clean wax from ears	Debrox, hydrogen peroxide
Clean wounds	Phisoderm, hydrogen peroxide, Betadine
Colds	Sudafed, Benedryl
Cold sores, chapped lips	Carmex, A&D ointment, Orabase, Oragel, Abreva
Constipation	Docusate sodium, milk of magnesia, glycerin suppositories
Cough	Robitussin DM, Mentholatum, various throat lozenges
Cuts, scrapes, lacerations	Neosporin, Betadine
Diarrhea	Immodium
Eye irritation	Artificial tears, Visine AC, eye wash, Clear Eyes
Ingrown toenail	Outgrow
Irritated skin, bug bites	Aloe gel, Calamine, Cortaid, Benadryl cream, Solarcaine
Lice treatment	Pronto
Minor burns/sunburn	A&D, aloe vera gel, Noxema, Second Skin
Pain, fever, headach	Tylenol, Advil
Sore muscles	Ben gay, Epsom salts
Sore throat	Various throat lozenges, chloroseptic spray
Sore rectum	Preparation H, Desitin
Upset stomach	Gaviscon, Maalox, Dramamine
Warts	Duofilm, Mediplast, Compound W